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POLICY ON REGISTERED NURSE FAILURE TO REPORT CHILD ABUSE

It is the policy of the State of California to protect children from violence and abuse.

The California Legislature has mandated that any health care provider, including a registered nurse, who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment who he or she knows or reasonably suspects has been the victim of child abuse, report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and prepare and send a written report thereof within 36 hours of receiving the information concerning the incident. (Penal Code, Article 2.5).

Within a health care facility, internal procedures to facilitate reporting and apprise supervisors and administrators of reports may be established. However, the reporting duties are individual and no supervisor or administrator may impede or inhibit the reporting duties and no person making such a report shall be subject to any sanction for making the report. [Penal Code 11172(a)].

The Board of Registered Nursing is mandated to take disciplinary action against registered nurses found guilty of unprofessional conduct, which includes the conviction of any offense substantially related to the functions and duties of a registered nurse.

Failure by a registered nurse to report child abuse or suspected child abuse is a crime substantially related to the functions and duties of a registered nurse and therefore constitutes unprofessional conduct within the meaning of the Nursing Practice Act, Section 2761(a)(1).

In addition, failure by a registered nurse to report abuse or suspected abuse of clients of any age constitutes unprofessional conduct within the meaning of the Nursing Practice Act, Section 1761(a)(1).

ABUSE REPORTING RESPONSIBILITIES

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Reports of abuse -- to the elderly, to children, and to dependent adults -- increase annually. Concurrently, the obligation to report suspected or actual knowledge of abuse has grown stronger through legislative mandates. In fact, health professionals who fail to report abuse to the above groups (dependent adults were added in October 1985) may be liable for criminal penalties. Requirements to report go into effect when the RN or other health professional discovers abuse in his or her professional capacity or within the scope of his or her employment.

What must be reported?

The law differentiates between what must be reported and what may be reported. An RN must report the following cases:

- abuse of the elderly, when the RN has actual knowledge that the person has been the victim of physical abuse;
- abuse of the dependent adult, when the RN has actual knowledge that the person has been the victim of physical abuse, or if the RN observes a physical injury consistent with the victim's statements or other corroborating evidence; and
- abuse of children when the RN knows or reasonably suspects abuse to have occurred.

In all three categories, any other person may report certain or suspected abuse of any kind. Additionally, an RN may report knowledge or reasonable suspicion of mental abuse or suffering of elders, dependent adults, and children. "Reasonable suspicion" is defined as objective reasoning base on facts that would lead another reasonable person (drawing, when necessary, on training and experience) to suspect abuse.

What constitutes abuse?

Definitions of abuse vary from one category of victims to another. The elderly -- persons 65 years of age or older -- are protected by law from purposeful physical or fiduciary abuse, neglect, or abandonment. Physical abuse includes cruel or inhuman corporal punishment or injury by anyone who has care or custody of an elder, or stands in a position of trust with that person. Beatings, sexual assault, unreasonable physical constraint, or prolonged deprivation of food or water fall under this category. Fiduciary abuse refers to willful stealing or appropriation of property by a person in whose care the elder has been entrusted. Neglect includes, but is not limited to, failure to assist in personal hygiene or in the provision of food and clothing, failure to protect the elder from health and safety hazards, and failure to protect him or her from malnutrition. Abandonment is defined as the willful forsaking of an elder by any person who had the care or custody of the elder, under circumstances in which a reasonable person would continue to provide care.

Dependent adults -- persons between the ages of 18 and 64 whose physical or mental limitations restrict their ability to carry out normal activities or protect their rights -- are protected similarly.

Abuse of the dependent adult includes physical, sexual, or fiduciary abuse; neglect; intimidation; cruel punishment; any treatment that results in physical harm or mental suffering; or deprivation of goods and services necessary to avoid physical harm or mental suffering. In the case of the dependent adult, physical abuse is defined to specifically include assault and battery and assault with a deadly weapon.

Children -- those under 18 years of age -- are protected by law from physical or sexual abuse, willful cruelty, or unjustifiable punishment or corporal punishment or injury. Neglect or abuse in out-of-home care is also included. Sexual abuse includes both assault and exploitation; neglect includes both acts and omissions to act. A child receiving treatment by spiritual means pursuant to the law (Sections 16509.1 of the Welfare and Institutions Code), or not receiving medial treatment for religious reasons, is not considered a neglected child for those reasons alone. An informed and appropriate medical decision made by a parent after consultation with a physician who has examined the child is also exempted from the charge of neglect.

How to report:

Mandatory reports of abuse must be made as soon as practically possible by telephone; written reports must be sent within 36 hours. If two or more persons have knowledge of an incident and are required to report, a single report may be submitted and signed by one mutually agreed upon member. If the designated person fails to report, any other member may make the report. Reporting duties are individual; the law prohibits a supervisor or administrator from impeding or inhibiting reporting duties.

Reports are made to adult, elder or child protective agencies. Elderly agencies include the state Department of Social Services, the county probation department, or the nursing home ombudsman; dependent adult protective agencies are the county welfare or social services department; children's reporting agencies include the police or sheriff's department, the county probation department, or the county welfare department.

RNs who entered employment on or after January 1, 1985, must sign an employer-provided statement that he or she has knowledge of child abuse reporting requirements. All RNs must sign a similar statement acknowledging an understanding of the dependent adult abuse laws.

Failure to report dependent adult or child abuse as required is a misdemeanor, and will bee punished by imprisonment in the county jail for up to six months, a fine not exceeding $1,000, or both. Failure to report elder abuse as required also constitutes a misdemeanor, and is punishable by a fine of up to $1,000.

Your protection:

Health professionals required to make an abuse report cannot be found civilly or criminally liable for making the report. In the case of dependent adult and child abuse, reporters may also take pictures of suspected victims without fear of legal recourse. The law also protects health practitioners who following a request from a protective services agency, provide the agency with access to the victim.

Nevertheless, the legislature has declared that despite this immunity, there is some possibility that actions may be brought against reporting persons. To limit financial hardships that could occur in fulfilling legal reporting responsibilities, health practitioners may present a claim to the State Board of Control for attorney's fees for defensive action in which he or she prevails.

Recent legal activity:

In the area of child abuse, there has been considerable concern regarding the need to report consensual sexual activity of minors. In June 1984 the state Attorney General answered the question of what the reporting responsibilities are when a minor receives medical attention for a sexually transmitted disease, birth control, pregnancy or abortion. The opinion states that cases involving minors 14 or older must be reported only if there is a reasonable suspicion that the sexual contact was the result of child abuse, i.e., the consensual, abusive sexual assault or molestation. However, a person under 14 is presumed to be unable to consent to sexual activity.

Therefore, according to the Opinion, all sexual contact involving a person under 14 violates the law and the reporting laws require reporting where there is reasonable suspicion that a child under 14 has been involved in sexual conduct or has a sexually transmitted disease. This includes all girls who become pregnant or are aborted. However, the Opinion stated that request for birth control pills or devices does not necessarily indicate sexual activity and therefore need not be reported. In September, Planned Parenthood, American Civil Liberties Union, and the National Center for Youth Law filed suit asking for the court to declare that the reporting laws require reporting only of non-consensual sexual activity, rather than requiring the reporting of all sexual activity by minors under 14.

California's First District Court of Appeal granted a stay of enforcement of the reporting act as interpreted by the Attorney General and prohibited enforcement of the reporting requirement in cases of voluntary consensual sexual activity. A date for a full hearing has not been set.

A second development requires state agencies to send a statement regarding the child abuse reporting laws to persons who are receiving state licenses to practice a profession in which abuse reporting is required. The statement must be sent with the license; the law goes into effect January 1, 1986.

THE REGISTERED NURSE AS PATIENT ADVOCATE
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Through the years the registered nurse often has been the first to recognize situations which are not in the best interest of the patient and to report these situations to persons who could effect change -- for example, to report a questionable drug order to the physician who wrote the order or to report an incompetent health care provider to a nursing supervisor. Some RNs have not recognized these as instances of patient advocacy and have wondered how it would be possible to be both patient advocate and valued employee. As a rule, the two roles are not incompatible because in most instances the employer, the nursing supervisor and the physician are as anxious as the RN to act in the patient's behalf.

Reporting patient abuse is another example of patient advocacy. In 1985, in response to a request by the California Attorney General, the board adopted the position that failure of an RN to report known or suspected instances of client abuse -- physical, emotional, and sexual -- constitutes unprofessional conduct and is ground for discipline by the BRN.

The board's policy suggests that procedures may be established within agencies to facilitate reporting. In developing such procedures, it would be important to provide channels both for the reporting of situations requiring nursing decisions and of those requiring medical decisions. Some problems would be handled entirely within the nursing channel; others requiring medical judgment, such as whether an ordered treatment regimen is appropriate for the patient, would be referred for medical decision. Usually a staff nurse would report a situation to an immediate nursing supervisor, who would then have the responsibility to handle the problem appropriately.

If the reporting nurse, after reporting abuse, is not satisfied that the patient's interests are being safeguarded, the nurse must pursue the matter further within the appropriate reporting channel and if still not satisfied, must report outside the agency. The board's policy warns that reporting duties are an individual responsibility and that no supervisor or administrator may impede or inhibit the process or subject the reporting RN to any sanction for making the report.

The board has developed guidelines for content of patient abuse courses, which are available without cost upon request.

PRACTICE INSIGHT
Reprinted From The BRN Report -- Winter 1987

QUESTION:
The Board of Registered Nursing's standards for competent RN performance state that a competent registered nurse:

"acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided C. C. R. Section 1443.5(6).

I've heard that a nurse who acts as a patient's advocate would be risking her job and creating problems for her employer. Please comment.

ANSWER:
California law makes nurses responsible to protect patients. The following is a summary of a pertinent case in which a patient entered a hospital to give birth. Her physician was Dr. A. The following is a brief summary of the court decision:

"Prior to the birth of the child, Dr. A. had made an incision just to the left of the 12 o'clock position on the cervix to relieve a constrictive band of muscle. The incision was not sutured but pelvic packs were inserted to apply pressure to control the bleeding. Patient G. was then returned to her room. Nurse L., who assisted during the birth of the child, told the doctor on three different occasions, the last about 9:30 p.m., that in her opinion, the patient was bleeding "too much." Nurse L. testified that Dr. A. told her that the condition, as she described it, was normal in this situation. She also testified that Dr. A. instructed her on a testing method by which the rate of loss of blood could be measured. The nurse was instructed to perform the test on Patient G. She checked the patient at 9:45, 10:15 and 10:30 and found increasing blood loss. During this period, the nurse did not take Patient G.'s blood pressure, temperature, pulse or respiration. She did not call the physician. She testified that she did not call him because she had not completed testing for blood loss, and she did not think he would come anyway. The doctor's order sheet stated that he was to be called if the postpartum flow was greater than normal. At 10:15, Nurse L. thought an emergency existed. At 10:30 she thought the patient's condition was "pretty serious."

At 11:00 p.m., Nurse L. was relieved by Nurse K. who was advised by Nurse L. that Patient G. was bleeding too much, and that Nurse L. was very concerned by Dr. A's treatment regimen for the patient. About 11:10, Nurse K. observed that Patient G. appeared to be going into shock. The nurse could not locate the patient's pulse, and she was cold and clammy. Nurse K. called Dr. A. at about 11:15, and he arrived at the hospital about 11:25. Patient G. was taken to the delivery room where oxygen and adrenaline were administered. There was an attempt to give the patient a blood transfusion, but the doctor was unable to find a vein in which to insert the IV needle. Patient G. subsequently died of a hemorrhage from a laceration of the cervix. The evidence is clear that the two nurses realized the nature of the medical care that the doctor was administering to Patient G. should be questioned. It is elementary that the knowledge received during the course of their education and experience as nurses, is in legal effect, binding upon their employer, the defendant hospital.

It is apparent from the evidence with particular reference to the time of 9:30 p.m., 10:30 p.m., and11:00 p.m., that both nurses in the exercise of ordinary care could have safeguarded Patient G. and that this nonfeasance contributed as a proximate cause of her death.

Both nurses had enough time to have reported the facts and circumstances of Patient G.'s peril to a superior in the hospital corporation with the purpose that prompt and adequate measures be taken to safeguard the life of Patient G." (1)

Note that the court held these nurses negligent because they knowingly followed the physician's negligent orders. It is no defense in a negligence lawsuit for a nurse to claim that she was following a physician's orders when such orders are clearly negligent. The nurses in this case would have avoided civil liability for Patient G.'s death, and possibly the death itself, had they reported her condition to a nursing supervisor and/or to another physician, preferably to the chief of staff of the medical service involved, so that appropriate measures could have been taken.
The case summarized above holds that nurses have an independent duty to protect patients. In addition to potential civil liability, a registered nurse not meeting his or her duty to protect patients faces license revocation or suspension by the board.

(1) Goff v. Doctors General Hospital, 166 C.A. 2d314 (1958).
(The case summary above is by Robert D. Anderson, attorney. Mr. Anderson formerly was legal counsel for the Board of Registered Nursing and is now in private practice.)